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Improving Provider Payment in Medicare

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I. Introduction

There is widespread agreement that reforming how Medicare pays for its services has the capacity both to produce savings to the system and to encourage the provision of higher quality, more effective health care. The most recent example of how prevalent this view is can be seen from the overwhelming support given to the "Doc Fix," where an otherwise deeply divided Congress passed the MACRA legislation by a vote of 392 to 37 in the House and 92-8 in the Senate. While the vote reflected the strong desire of the Congress to have the perennial issue off the table and was able to pass it because the most contentious issue—how to avoid an increase in the deficit—was only partly addressed, the substance of the bill indicates a strong enough belief in the potential of reformed payment approaches, such as ACOs, bundled payments or medical homes, that physicians who participate in these mechanisms for a large enough portion of their practice will be paid at a higher rate.

This belief--that a set of metrics can be developed or delivery systems specified that could lead to the delivery of care that would both increase quality and improve efficiency—has not been diminished by the challenges that been observed in the early rounds of various demonstration and pilot projects. Many groups are still attempting to develop or refine the metrics that will capture both efficiency and relevant clinical outcomes and do so in a way that won't unreasonably burden the clinicians who are providing these services.

It is important to clarify our perspective on how the reforms discussed, which apply to the traditional Medicare program, relate to Medicare Advantage (MA). Many have commented that these reforms should be seen

as a transition to MA. At the level of a specific provider, this will sometimes be the case as changes in delivery to increase efficiency and raise quality undertaken under reformed payment in the traditional program results in acquisition of some of the skill set needed for an MA plan built around one or more delivery systems.

But we envision that many providers that succeed under the reformed payment models will see it as a longer-term proposition in which they achieve a better bottom line and quality of care than if they had remained in traditional FFS. Indeed, as MA continues to grow, these providers likely will be contracting with MA plans (and insurers covering younger populations) using these reformed approaches. Ultimately, presuming a level playing field between traditional FFS and MA is achieved by the Congress and the Administration, the shares of these two components of the Medicare program will be determined by beneficiaries considering the costs to them and the quality of care between these two options.

II. What Have We Learned to Date?

Several types of payment reform strategies currently are being piloted. These include the patient centered medical home (PCMH), which began before the ACA was passed, an advanced payment version that combines public and private payers, and a bundled payment initiative that involves different payment strategies across different provider types (e.g. hospitals and physicians, hospital and post-

acute care providers etc.) The ACA also defines ACOs, allowing groups of physicians and physicians and hospitals that are not formally organized to take partial financial risk for how spending per attributed beneficiary compares to a benchmark. ACOs have had a choice of taking only one-sided risk, i.e. to sharing savings with the Government but not losses or to take two-sided risk where they can earn higher levels of savings but also be subject to losses. To date, most ACOs have chosen to share only savings. A more advanced model is also offered--called Pioneer ACOs--for groups that have had experience taking risk in providing care to patients. Pioneer ACOs can share in larger gains but are also subject to losses.

Many of the pilot programs are still relatively early in their implementation phase and only a few have released formal independent evaluations, so at this stage any conclusions should be regarded as tentative. In addition, most PCMH results have been reported by the payers organizing the medical homes rather than by independent evaluators. The very few independent evaluations have reported no or very small savings. A recent study of the Pioneer ACOs suggested small savings the first year (that is, lower expenditure trends) and even smaller savings the second year. [ref] In addition, almost half of the groups that initially agreed to become Pioneer ACOs have dropped out—either because they were losing money or thought the risk-reward options offered by CMS did not justify continued participation.

While it is still early to draw conclusions, it appears that the types of models that are being tested to date have shown either no results or modest savings. Fortunately, the dominant response has been to focus on the need to refine the models rather than abandoning the idea of payment or organization reform. It is also clear that timely, independent evaluations are critical to assessing current strategies so that timely adjustments can be made as appropriate.

The wide range of reforms being undertaken simultaneously and their rapid evolution is a challenge for evaluation. Earlier feedback will be important in making refinements to the models. Probably the best source of early information is provider decisions about participating in the programs offered, along with CMS discussions with providers. Although the process took far too long, the CMS response to the many providers who dropped out of the Pioneer program of creating a new option—Next Generation—provides some encouragement about the existence of such a feedback loop.

III. Changes Needed in Current Medicare Models

In contrast with the broad enthusiasm in the payer and policy communities and provider leaders for payment approaches that diminish the role of fee for service, the actual models that CMS has been implementing in pilot programs have not been well received by providers. In some cases, this has led to providers participating because they are confident the models will soon evolve, in others only as a transition to a Medicare Advantage initiative and in others the providers are not participating. To us, the strong resistance of providers to taking two-sided risk is as likely to reflect a lack of confidence in the models and metrics as it is to being an aversion to risk.

The design issues needing the most attention include:

- Benchmarks
- Beneficiary engagement
- Quality measurement
- Development of bundles for a wider range of episodes
- Incorporating post-acute services into more payment approaches

Benchmarks

A benchmark is the target rate of spending per beneficiary or per episode for the provider entity that is contracting with the Medicare

program. Medicare to date has used benchmarks that are based on the provider's historical spending per beneficiary per year or per episode. This spending is trended forward by recent and projected program experience. CMS has tweaked this by using a trend expressed in dollars rather than a percentage change, so that lower-cost providers get a relatively more generous trend.

An advantage of provider-specific benchmarks is that large numbers of providers perceive an opportunity to succeed under a reformed payment approach. But the providers that are most efficient will find it more difficult to achieve further savings. A provider-specific benchmark rewards improved performance but not good performance.

As long as provider participation is voluntary, provider-specific benchmarks appear to be essential, at least as a first stage in a transition. Uniform regional or national benchmarks would create an adverse-selection phenomenon where low-cost providers would volunteer in order to get paid more for continuing their efficiency, while high-cost providers would not participate since they would have to increase efficiency a substantial amount to avoid losses.

But provider-specific benchmarks cannot and should not continue very long. If the benchmarks are recalculated using more recent spending data, this would substantially undermine the business case for participation. Increasing efficiency often requires significant investment. If the benchmarks are recalculated after three years, it means that only three years of potential shared savings could be achieved by the investment. It is possible that investments could lead to gains in efficiency that increase year after year for a long period of time, but we have not heard about such models. This is not an assumption you would want underlying a program. CMS appears to be making this mistake in its Bundled Payment for Care Improvement (BPCI) initiative, where benchmarks are updated very frequently based on each provider's spending.

Any undermining of the business case could be mitigated by the continued use of the original benchmark, using national trend factors to adjust the benchmark for an additional few years. But few would advocate continuing to set benchmarks based on what a provider's spending was six, eight or more years ago. Since the initial Medicare ACO contracts are coming up for renewal, it is important for CMS to make and publicize the decision on benchmarks for the second round as soon as possible. Until that happens, uncertainty is likely to limit provider investments in improving delivery.

Approaches to benchmarks beyond a transition period need to use elements of compulsion, as Medicare has done over many years for other elements of payment reform. Many analysts believe that for some types of episodes of care, such as joint replacement, bundled payments are promising enough to mandate them. Arkansas' Medicaid program has mandated bundled payment for selected episodes and established benchmarks based on statewide data. Under a mandate in Medicare, the benchmark could transition over a period of four years from provider-specific to a national benchmark with adjustment for input prices. This was the approach that Congress used in 1983 when it enacted the Inpatient Prospective Payment System. If a voluntary approach had been used, Medicare might never have progressed beyond cost reimbursement! While the physician fee schedule is not exactly comparable to other aspects of perspective payment in Medicare, it is prospective in the sense that it is not shaped by provider-specific data.

More limited degrees of compulsion are possible as well. Alternative payment approaches could continue to be voluntary but providers given stronger incentives to choose them. This was seen in the recent legislation to fix the Sustainable Growth Rate (SGR). Physicians will have an opportunity to be paid rates that are 5 percent higher if the proportion of their services paid for under "alternative payment mechanisms" (APM) exceeds a

threshold. We expect substantially increased interest in these approaches on the part of physicians and political pressure on CMS to develop additional payment approaches that would qualify. For example, bundled payment approaches for important services in some specialties, such as oncology, need to be distinct from the one used for joint replacement. Incentives like what the SGR fix created for physicians could be created for hospitals and other providers as well.

Once broad provider incentives to volunteer for alternative payment approaches are in place, there is more of an opportunity to diminish the role of provider-specific benchmarks. This would permit regional or national benchmarks to be blended with provider-specific benchmarks, though not as aggressively as under mandatory participation. While national benchmarks would be appropriate for bundled payment, regional benchmarks, such as counties or metropolitan areas, may be more suitable for population-based approaches, such as ACOs or medical homes. This is because of our limited understanding of variation in rates of service use across regions.

The Congress addressed these issues for Medicare Advantage payment by limiting the variation in rates across counties in relation to variation in spending.. This approach could be used for ACOs and perhaps for advanced medical home models in which primary care physicians are at risk for overall spending by their panel of Medicare beneficiaries. Indeed, it is important that ACO benchmarks align wherever possible with benchmarks for Medicare Advantage. Under the current situation, delivery systems have strong incentives to choose between an ACO strategy and a Medicare Advantage strategy depending on how their costs per beneficiary compare to others in their region. Those with high costs are likely to focus on ACOs, while those with low costs have an incentive to not pursue ACOs but instead to create a Medicare Advantage product that is built around its delivery system, either on their own or in partnership with an insurer. Such a selection process, which is clearly underway, could be costly for the Medicare program.

Beneficiary Engagement

The Medicare Shared Savings Program, which was created through specific legislative provisions, essentially excluded any role for beneficiaries in ACOs. The only significant beneficiary provision created an option for beneficiaries who are attributed to an ACO to block the ACO from accessing data on services received from providers outside of the ACO. Many believe that ACOs can accomplish the most through enhanced management of chronic disease, providing support to patients to encourage greater compliance and coordinating care provided by multiple specialists and facilities. ACOs need to be able to engage beneficiaries to realize this potential.

Through comments to CMS, many ACOs have made suggestions to foster greater beneficiary engagement. Beneficiary attribution to ACOs could be done prospectively instead of retrospectively, allowing ACOs to know whose care they are responsible for and better targeting outreach to beneficiaries to provide support. Some have suggested that beneficiaries be given an opportunity to attest to the fact that they have a primary care physician in an ACO. The ACO might offer those beneficiaries a waiver of Medicare cost sharing for visits to their primary care physician. The provision in MACRA that prohibits Medigap insurers from filling in the Part B deductible will help make this more effective. CMS, in its proposed “Next Generation” ACO model, incorporates some of these suggestions.

A network approach to ACOs, which would require legislation, would strengthen beneficiary engagement further and address some other shortcomings as well. Under a network approach, ACOs would create a network of physicians and potentially other provider types that they believe provide care that is more efficient and at higher quality. Beneficiaries using these providers would get

reduced Medicare cost sharing. Those using providers outside of the network would pay additional cost sharing. These variations in cost sharing could be made by the ACOs directly or by Medicare. Full choice of provider in traditional Medicare would continue, as would current limits on balance billing for those providers not accepting assignment. But ACOs would have another mechanism to steer those who have signed attestation forms to providers believed to be superior. Beneficiaries might also be offered a reduction in their Part B premium in return for agreeing to this arrangement. Again, this payment could either be made by Medicare or by the ACOs.

A network approach would also provide a mechanism to engage more physicians and other providers in ACOs. ACOs must have primary care physicians, but many specialties are not typically included by ACOs. This could potentially pose a problem for implementation of the APM provision of MACRA, where physicians need to meet thresholds for activity in APMs to qualify for payment rate bonuses. Under the network approach, ACOs would have to include physicians in each specialty in their network, even if they chose not to offer involvement in the leadership of the ACO and a sharing of savings and losses to those specialists.

For the network approach to be effective, further changes in rules for Medigap coverage would be needed. Beyond the MACRA provision concerning the Part B deductible, restrictions on filling in coinsurance would be needed so that reductions associated with using network providers or increases for using non-network providers would not be fully offset.

Quality Measurement and Alignment Across Payers

Quality measures should be an important part of alternative payment approaches. The public no longer assumes that medical care quality is high; the Medicare program needs to measure quality, make it publicly available and incorporate it into payment. Although FFS has not insured good quality, concerns with alternative payment and its incentives to provide less care make incorporation of quality measures particularly important.

To date, quality has been incorporated into payment by requiring high levels of quality before shared savings payments can be made by providers. This direction should continue because the ability to potentially trade off costs and quality appears to be a long way off. It may never happen, at least for public payers, which would have difficulty stating explicitly that they have sacrificed some quality in order to save money.

Ultimately, beneficiaries are best positioned to make these tradeoffs. So priority needs to be given to developing quality measures that are meaningful to beneficiaries and aggregating them in a way that can make complex data more accessible. After years of evolving star ratings for Medicare Advantage plans, CMS recently began to issue star ratings for the patient-focused aspects of hospital quality. While this is a positive trend, there is always the danger that aggregating different measures produces a number that isn't very meaningful. An approach like the star ratings could ultimately be applied to ACOs, assuming a meaningful metric can be developed. This could be especially useful in an environment (described above) in which beneficiaries actively choose ACOs.

Providers have expressed serious concerns about the current situation of different payers using different quality measures in their alternative payment initiatives. Not only does this increase the expense of developing the measures required by each but it means that providers lack clear directions about what aspects of quality are most important. Private insurers and Medicaid programs using different measures from Medicare is at odds with longstanding experience of alignment in other areas. In coverage decisions and hospital and physician payment, the record has been one of

other payers following much of what Medicare does. Why has this not happened so far in quality measures or, more broadly, in design of alternative payment approaches? Presumably it would be easier to follow Medicare. Perhaps the problem is that Medicare to date has not done the best job.

While more alignment would certainly be desirable, we believe it would be a bad idea to require others to follow Medicare. What is needed instead is meaningful communication between the various payers. A promising process is the collaboration of America's Health Insurance Plans with CMS and the National Quality Forum on aligning quality measures. The collaboration has had input from physician specialty societies and plans to bring employers and consumers into the process as well [ref to *Moving Ahead on Transparency in Health Care Quality: A Public-Private Collaboration Frequently Asked Questions*, AHIP March 2015]. Such collaborative processes could also be used to enhance other aspects of designs of various alternative payment approaches. CMS' recently announced *Learning Action Network* might also contribute to this goal.

Expanding Range of Services Included

Although some of earliest initiatives for reformed payment included only hospital and physician services, inclusion of additional services would expand the opportunities to reduce costs and increase quality. As the recent IOM report on geographic variation in Medicare spending showed, post-acute care, which includes skilled nursing facilities, rehabilitation facilities and home health services, is by far the most important factor behind variation in overall spending.[1] Fortunately, Medicare ACO models currently do include post-acute care. But many of the bundled payment models do not. For example, with rehabilitation such an important part of joint replacement, excluding it from a bundled payment limits what can be accomplished by providers in terms of increased value.

Part D prescription drugs have also been excluded to date, presumably due to the substantial administrative challenges. Claims systems, which are run by the Part D insurers, are separate. In addition, a mechanism would have to be developed to transfer a portion of the savings accruing to the Part D plan to the providers that are taking risk including drug spending. The savings remaining with the insurers would be expected to flow to Medicare through lower future bids, which in turn would reduce the Part D benchmarks.

For situations in which drugs are an important part of spending, such as chemotherapy episodes, making the effort to include drugs would be well rewarded. Indeed, CMMI recently created an oncology bundle for chemotherapy that does include both Part B (physician-administered) and Part D drugs [ref]. Indeed, claims for drugs trigger an episode, which runs for six months.

Additional Bundles

To date, most bundled payment has been for episodes triggered by a stay in an acute hospital. As care continues to shift from inpatient to outpatient settings, there likely will be substantial opportunities for bundled payment for episodes of care that do not require an inpatient stay. In contrast to acute inpatient episodes, where CMS could provide very general rules through offering four possible bundled payment models, outpatient episodes will require more detailed judgement to create attractive bundles.

For outpatient episodes, CMS should specify those eligible for bundled payment, starting with high-volume episodes. Characteristics of promising episodes would include substantial variation in spending from provider to provider, a relatively small number of providers to coordinate, especially those who already have significant interactions, where there are relatively clear objective clinical guidelines that trigger the episode and where the treatment is not especially supply sensitive. [ref to BPC Jan

15 report]. A screening colonoscopy would be an example of an episode with a number of these characteristics.

Opportunities include selected chronic episodes, where the episode is defined by a period of time, as well as acute episode. The major challenge in this area is conditions where variation in severity has important implications for resource use. Chronic diseases that can be "staged" (e.g. stages 1 through 4 of congestive heart failure) are more likely to lend themselves to bundled payment. It may also be necessary to differential bundled payments involving a chronic disease that includes co-morbidities that could affect treatment choices as for example would be the case for complex diabetes with CHF or other co-morbidities.

III. Path Forward to Reformed Payment

If payment models can be improved along the lines discussed above, how can policymakers chart a path so that the reformed payment models become the norm in traditional Medicare, leading to a greatly reduce role for FFS? This section sketches a number of components of such a strategy. It includes mandating reformed payment for services where confidence in the model is high, incentives for providers to voluntarily choose reformed models and resolving situations in which providers participate in more than one model that affects services for a beneficiary.

Mandate Some Payment Reforms for Medicare

Once there is sufficient confidence in the merits of specific reformed payment models, their use should be mandated. Mandating reformed payment is what Medicare has done traditionally and provides several important advantages relative to a system of voluntary payment reforms. First, the gains in efficiency and quality will affect more beneficiaries. Second, opportunities for federal savings will be greater, both because more services will be included under the model and because the federal government can garner more of the savings over time. Third, the problems with benchmarks discussed above can be resolved so that at the end of a transition, rewards can go for good performance by providers rather than only improved performance. And fourth, the problems of self-selection that plague all voluntary programs can be avoided.

We believe that such a mandatory approach can be applied at this time to at least selected episodes. Policymakers already know a lot about bundled payment for joint replacement and certain cardiac procedures through the ACE demonstration and the CABG demonstration from the 1990's. [2]. There is a lot of experience with these episodes in BPCI and many private insurers have been contracting for these services on a bundled basis for years. As CMS develops additional episodes, bundled payment could be mandated, using a transition payment model to move from the present fee for service payment to the bundled payment.

Incentives to Encourage the Adoption of Reformed Payment

MACRA offers a 5 percent bonus payment to physicians with a high enough portion of revenues from *Alternative Payment Mechanisms* (APM). This does not begin until 2019 and a lot of work will be required by CMS to establish which APMs should be eligible. The potential for bonuses is likely to increase participation in reformed payment strategies. If particular types of strategies dominate, Congress should consider whether to mandate them—or give CMS the authority to do so. A potential problem with the specific approach authorized by MACRA is that a wide range of APM models might be approved, making eventual consolidation into one or a small number of approaches far more challenging. However, as long as the various approaches produce auditable savings, it is not clear this represents a "bad outcome".

The notion of offering higher payments to providers for participation in APMs could be expanded to institutional providers. This might

not be as easy as with physicians, who had the threat of the SGR hanging over them and ultimately agreed to a long period of very low updates along with the opportunity of a 5 percent bonus and a share of savings under the APMs. The experience from the quality reporting program a decade ago indicated that hospitals changed their behavior in response to relatively small bonus payments.

Coexistence of Different Payment Approaches in Medicare

Because of the multiple pilot projects currently being tested, some physicians are part of or subject to multiple changed incentives, each sometimes providing for an increase in payments. For example, an orthopedic surgeon could be part of a group participating in a bundled payment for joint replacement. Some of the beneficiaries having a joint replacement with this physician may be attributed to an ACO, where the surgeon may or may not be a member of the ACO. Under current policies, CMS will subtract the savings from the joint replacement that are shared with the surgeon's group from the savings calculated for the ACO. This avoids double payment for savings under an episode of care.

But this appears to undermine a potential strategy for ACOs to achieve savings—to encourage beneficiaries attributed to the ACO to go to surgeons who are more efficient per episode of care. Indeed, we might ultimately want to evolve the ACO model so that the ACOs share savings per episode achieved with the physicians that treat ACO patients; in other words, implant approaches like bundled payment and medical homes into a new model of ACOs or at least make sure that policies aren't adopted that would discourage such behavior.

Or we could move in an opposite direction, which would involve a medical home model that places primary care physicians at risk for overall spending for beneficiaries attributed to them, perhaps on an upside only basis, and a bundled payment model for episodes of care. This could make the ACO superfluous.

The point for now, when trying out numerous payment reforms simultaneously makes sense, is to make sure steps are taken that achieved savings are not rewarded more than once, but to do so in a way that doesn't inadvertently undermine the most promising models.

IV. Conclusion

Realizing the potential of reforming payment in the traditional Medicare program will require improvements to the payment models offered to providers. This will be the key to realizing HHS Secretary Burwell's ambitious goals to expand the role of these approaches in Medicare. Getting large provider participation not only allows more beneficiaries to gain better outcomes of care, but also permits the critical step of moving away from provider-specific historical benchmarks to those based on regional or national experience. Voluntary participation is not a viable long-term strategy.

References

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